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COMMENTARY

Revisiting the Social History for Child Health

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BEGINNING as early as John Snow and Rudolph Virchow, physicians have recognized a link between social circumstances, population dynamics, and disease.[1] Although some social factors have been improved, such as clean drinking water, others such as unsanitary living conditions, crowding, hunger, and homelessness continue to contribute to poor health in the United States. Currently, the social history generally focuses more on health behaviors such as sexual practice, alcohol use, and smoking and less on the social circumstances of patients' lives. New research, however, has helped elucidate the mechanisms by which social circumstances affect health, and new resources have been created to mitigate these factors and thereby improve health. Medical care must evolve to include screening for selective social factors into clinical practice to augment public health and social policy strategies. Consistent with a call from the Institute of Medicine to better incorporate social and behavioral sciences into medical training,[2] we suggest that the primary tool that identifies the social circumstances of the patients, the social history, be revisited. We make the case for improved social history, particularly in children, although similar cases can be made for the elderly or other adults.

JUSTIFICATION FOR REVISITING SOCIAL HISTORY

New Research

Beginning as early as 1976 with the work of Cassel[3] and Syme and Berkman,[4] the field of social epidemiology has demonstrated how social conditions influence the etiology of various diseases by creating or taking advantage of general susceptibility within populations. Over the last decade, there has been a rapid increase in the quantity of biomedical and health services research, which links elements of the social environment to mental and physical well-being.[5] One example is the social determinants of asthma. Various studies have suggested a link between stress,[6] housing conditions,[7] and homelessness[8] and a higher prevalence and severity of childhood asthma.

Asthma, however, is not the only example of social environment affecting health. Substandard housing and homelessness have been linked to higher rates of diarrheal illness and ear infections and increased health service utilization.[9] A "heat-or-eat" phenomenon, by which low-income children who live in cold climates experience impaired growth in the winter because family finances are diverted to heat the home, has been documented.[10,11] Inadequate school services for children with learning and behavior issues can lead to school failure,[12] which has been connected with poor health behaviors and poorer health as an adult.[13] Alternatively, attendance at structured day care has been associated with improved school readiness and other improved developmental outcomes.[14]

In addition, parent-level factors, many of which are associated with structural social circumstances, impact children's health and school functioning. For example, social factors contribute to depression,[15] and many studies demonstrate the association between maternal depression and child problems.[16–19] Recent evidence indicates that family or community violence exposure has a synergistically negative effect on child school function when combined with parental depression.[20] Although

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the amount of observational data is limited, low or marginal health literacy among parents can impact child health care utilization and outcomes,[21] particularly for children with chronic conditions.[22–24] Conversely, literacy programs such as Reach Out and Read, have shown improved language development that can be associated with improved health literacy from simply handing out books and counseling to read during well-child visits.[25]

In an attempt to synthesize some of this material, the World Health Organization issued its first edition of *The Social Determinants of Health: the Solid Facts* in 1999, followed shortly by a second edition in 2003.[26] The editors commented on the relevance of this evidence to public policy but stopped short of applying this information to assessing individual patient risk. They also did not suggest methods for assessing these factors in clinical practice. We argue that there can be implications for clinical practice for identifying selective social risk factors.

New Resources

Because social determinants of health are often perceived as irremediable, clinicians may avoid discussing social determinants of health with their patients. Sugg and Inui[27] addressed the phenomenon of "Pandora's box" in reference to why clinicians may avoid conversations about social factors, with domestic violence being addressed specifically in their article. Efforts over the past 15 years that have focused on the importance of domestic violence, however, have resulted in a significant change of awareness and emphasis on the importance of identification of this problem in clinical practice. It is likely that one of the main factors motivating this change in practice was expanded awareness of such circumstances and the actual amount of resources to protect victims, such as restraining orders, safe houses, etc, potentially giving clinicians a means to address problems when they are uncovered. Although interventions that address the social context of children's lives have been implemented nationally, such as the Supplemental Nutrition Program for Women, Infants, and Children (WIC) nutrition program, the State Children's Health Insurance Program (SCHIP), early intervention (EI), and Head Start, clinical practice still requires the identification and referral of eligible children for these programs and other potentially effective interventions.[28,29]

Social workers and case managers were initially added to health care teams to address such factors when identified by social history. However, the development of new laws and regulations, which may even exceed the expansion of medical innovations, has limited social workers' effectiveness, because they are not trained in the law. Many health care teams around the country have joined forces with legal aid lawyers (eg, see www.mlpforchildren.org or www.legalhealth.org) to more effectively address some of the social antecedents of poor health. Indeed, unlike doctors who can identify social factors that are contributing to poor health but have little capacity to effectively address them, lawyers have the knowledge and skills to remedy many unmet basic needs.[30]

THE TRADITIONAL TEACHING AND USE OF SOCIAL HISTORY

Social history–taking techniques are often introduced in the preclinical years when the educational focus is on biology and interaction with patients is limited. This teaching, which may be isolated from meaningful contact with patients, makes translating the impact of social factors to clinical practice difficult. Most textbooks for medical students on history and physical examination traditionally devote a paragraph to the social history prefaced by stating that the social environment is vital for understanding the condition of the patient. After this, a long list of questions pertaining to upbringing, education, finances/employment, housing, relationships, religious/spiritual affiliations, recreational interests, stressors, and behavioral risk factors follows with no particular justification for how they could affect health.[31,32]

In the clinical years, the social history is often reduced to a collection of the patient's personal health behaviors (alcohol consumption, tobacco use, intravenous drug use, and sexual behavior) as it relates to a patient's medical condition. With this practice, students get further removed from other real social-environmental factors that can have a direct bearing on the cause and management of disease. In some internal medicine clinical textbooks, reference to the relevance of a general social history is infrequent or absent.[33,34] In pediatric texts, the components of social history generally comprise the number and relationship of people in the household[35–37] and may also include whether there is the presence of grandparents, marital status of the parents, who the primary caretaker is, who the primary disciplinarian is, help for the primary caretaker, if the parents work at or away from home, day care, smoking in the house, how much television the child watches, and the child's extracurricular activities. Although many of these factors are important, the questions about them are rarely followed by a discussion of why and how they are relevant to the patient's condition. Most importantly, these texts have failed to address the basic needs for health in low-income families: adequate food and housing, safety, and access to health care, mental health care, or, in the case of children, appropriate education.

Given this important gap in information, it seems opportune to revisit the social history to augment advances in medical care that will improve the health of children. As the potential of the genome project in identifying susceptibility genes for complex diseases progresses, greater attention to genetic and social-environment interactions will become increasingly impor-

tant to understanding and intervening with the onset and course of diseases.

AN OPPORTUNITY

Given the effects of social circumstances on health outcomes and the Institute of Medicine's recommendation to better incorporate the social and behavioral sciences into medical education, there is a great opportunity to revamp the teaching and practice of taking a social history. This underused tool, which is intended to tie a patient's medical illness into the context of his or her life, is an opportunity to teach the clinical relevance of social factors in medical education. If done appropriately, this teaching could parallel the scientific rigor of other aspects of the curriculum while receiving the necessary attention it deserves.

A more uniform, comprehensive, and rational approach to teaching the social history would incorporate research alluded to earlier, such as that presented in the World Health Organization report[13] regarding the effects of transportation, job and housing stress, social isolation and integration, and early childhood experiences on health and well-being. From a pedagogic standpoint, integrating the evidence-supported social determinants of health with other preclinical or clinical teaching would elevate the social history to the accepted status of the history of present illness, the physical examination, or the formulation of an appropriate evidence-based treatment plan.

Admittedly, there is minimal evidence that asking these questions and knowing this history would necessarily change outcomes. However, with new resources such as enhanced case management services and legal aid attorneys, physicians and health care teams have a chance to affect better outcomes. If no one on the health care team asks, and health providers remain ignorant of these social realities, these factors will continue to adversely influence health. Although laws and public health regulations, if applied, would prevent some health problems, lawyers are part of the solution for individual patients because some problems such as poor housing conditions, denial of public benefits for food, housing, etc represent violations of such laws. Therefore, learning and applying the social history to true social antecedents of disease such as hunger and substandard housing conditions—not limiting them to health behaviors such as smoking, drinking, and drug use—is the first step in a process that ultimately must involve additional research into screening methods that evaluates interventions and measurement of improvement in health.

The Guide to Community Preventive Services,[38] a project of the Centers for Disease Control and Prevention, has already begun the process of outcomes assessment on existing interventions that address social-environmental factors such as early intervention and housing vouchers. This and other similar efforts have the potential to further elevate the social history to an evidence-based, outcomes-oriented tool. If we consider social history to be a screening tool similar to these others, it is clear that it should not be held to any lower standard than other screening tools. Asking questions of social history is an inexpensive intervention, but it would be important to identify which questions are able to uncover social problems with enough sensitivity and specificity to be useful in clinical practice. Also, once certain social problems are detected, such as inadequate housing, there would need to be an efficacious intervention to offer (eg, assistance applying for tenant-based rental assistance).[39]

A PRACTICAL APPROACH TO THE SOCIAL HISTORY

Although eliciting a history of social circumstances with each part based on well-supported connections to health and in areas of patient's lives that clinicians can actually influence is the goal, we acknowledge that the current level of data may be insufficient to establish a definitive model. Given this constraint, we suggest a practical method for eliciting a social history that focuses on specific social domains similar to a model proposed by Green et al.[40] Their model consists of 4 domains for the social context: (1) social stressors and support networks; (2) change in environment; (3) life control; and (4) literacy. Pediatricians generally address some of these issues already, such as knowing who a child lives with and where they are from. However, basic needs such as income, food sufficiency, and health environments at home and in school, which are crucial to children's health and well-being, are not routinely addressed.

Building on this model, we propose a more explicit set of domains and questions (see Table 1) that allow for more-specific inquiry into areas that are amenable to direct intervention that focuses on basic needs and factors that influence health. Using the mnemonic "IHELLP," our model addresses income, housing/utilities, education, legal status/immigration, literacy, and personal safety, each of which has been shown to directly impact child health.

This approach to the social history could be applied over a series of health care visits or in a focused manner if one of these areas is identified as a significant contributor or risk factor for poor health. See the Appendix for an example of how this approach might be used during a health care visit in the domain of housing.

A LOOK TO THE FUTURE

Beyond expansion of what composes a social history for the individual patient encounter, we encourage medical educators to incorporate how to address the social determinants of health into the curricula at both the graduate and undergraduate medical education levels. One technique used at Boston Medical Center and Boston University School of Medicine is for lawyers on the staff

TABLE 1 **Examples of Potential Social History Questions (Using the "IHELLP" Mnemonic) to Address Basic Needs**

Domain/Area	Examples of Questions
Income	
General	Do you ever have trouble making ends meet?
Food income	Do you ever have a time when you don't have enough food? Do you have WIC? Food stamps?
Housing	
Housing	Is your housing ever a problem for you?
Utilities	Do you ever have trouble paying your electric/heat/telephone bill?
Education	
Appropriate education placement	How is your child doing in school? Is he/she getting the help to learn what he/she needs?
Early childhood program	Is your child in Head Start, preschool, or other early childhood enrichment?
Legal status	
Immigration	Do you have questions about your immigration status? Do you need help accessing benefits or services for your family?
Literacy	
Child literacy	Do you read to your child every night?
Parent literacy	How happy are you with how you read?
Personal safety	
Domestic violence	Have you ever taken out a restraining order? Do you feel safe in your relationship?
General safety	Do you feel safe in your home? In your neighborhood?

WIC indicates Supplemental Nutrition Program for Women, Infants, and Children.

of the Medical Legal Partnership for Children to instruct pediatric residents during a 2-week primary care block on methods for accessing public-benefit programs or improving substandard housing. We use teaching tools, such as a poverty simulator from the Missouri Association for Community Action (http://communityaction.org/Poverty%20Simulation.htm), and developed our own tools, such as advocacy code cards and advocacy clinical practice guidelines (www.mlpforchildren.org/training_education.aspx). These teaching activities led to the creation of the IHELLP mnemonic for assisting residents to remember all the social factors to address over the course of caring for a patient followed in a primary care or specialty care setting. The evidence behind the impact of social factors on health should also be incorporated into courses that introduce medical students to clinical medicine or epidemiology and into public health courses targeted at clinicians. In addition, this would bolster teaching a more-rational and better-evidenced social history.

CONCLUSIONS

The body of medical knowledge is estimated to double every 5 years. It is the daunting and accepted task of academic medical centers to adapt new knowledge to the education of future physicians. The traditional focus of this effort has been on incorporating new, relevant, and strongly supported biomedical research and, more recently, research from the behavioral sciences into clinical training, but there has not been a substantial effort to incorporate research that has described and quantified the effects of "true" social factors on health. As the mechanisms in which social determinants of health produce health disparities become more and more clear and there are more interventions to mitigate them, it will be increasingly important to educate physicians on their relevance to clinical practice. It is time for a new approach to teaching the social history in the 21st century for the health of all children, families, and adults.

APPENDIX

Mrs Winters brings in Ellie, her 7-year-old daughter with a history of previously well-controlled mild-persistent asthma, for a well-child visit. She states that her daughter has generally been in good health but that she was recently hospitalized for the first time for a significant asthma exacerbation. After further inquiry into the cause of this hospitalization, you inquire about the family's current housing situation. You learn that the Winters family is currently living doubled-up with a grandmother and that Ellie, her brother, her mother, and her father all sleep on the floor in the living room. The grandmother has a cat, and her house has a "significant amount of dust" per the mother's report. Both of these are known triggers for Ellie's asthma. Delving deeper into the cause of the current change in housing, you discover that Ellie's father recently lost his job, and the family was evicted from their previous apartment, where they lived as a nuclear family, after 2 missed rent payments.

Concerned that the landlord improperly evicted the family and that, regardless of the cause, the family needs help finding more suitable temporary and long-term housing given Ellie's environmental triggers, you consult a medical-legal partnership affiliated with your health center. A lawyer from this program is able to place the family on an emergency housing list and connect them with information regarding emergency shelters. The lawyer also discovers that the family was evicted without a notice to quit, which is a violation of the law, and leverages the landlord to reinstate the family into their former housing. The lawyer, family, and landlord negotiate an agreement for repayment of back rent that is contingent on the family's ability to pay their current monthly rent. As Ellie's asthma is followed, her asthma symptoms improve after these changes have been made.

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